OPT OUT CANCELLATION FORM

Providers currently receiving monthly electronic notification (e-mail) of *Medi-Cal Updates* through the OPT OUT service may discontinue the OPT OUT service at any time and resume the monthly hard copy (printed) *Medi-Cal Update* service.

Directions: Enter your contact information directly into the form by clicking each of the fields below. However, you must then print and sign the form before mailing it to EDS. An original signature is required; therefore, the form may not be submitted online. If you elect to complete this form by hand, please **print legibly in black ink**.

Provider/Group Name: _____ Medi-Cal Provider Number: _____

Contact Name
(if different from above): _____ Phone Number: ( ) _____

Address: _____

PLEASE PRINT LEGIBLY

_____ __

City State Zip Code
enter the 9 digit code to expedite mail delivery

I would like to receive hard copy (printed) *Medi-Cal Updates* via the postal service. I no longer wish to receive e-mail notification of *Medi-Cal Updates* on the Medi-Cal Web site (**www.medi-cal.ca.gov**).

_____
Provider/Authorized Provider Representative Signature

_____ _____
Printed Name of Signee Date

Please allow time for EDS to process the *OPT OUT Cancellation Form*.

Mail this completed form to:

General Services and Distribution
EDS
P.O. Box 13029
Sacramento, CA 95813-4029

For assistance, contact the Telephone Service Center (TSC) at:

1-800-541-5555

EDS Use Only
Cancelled: _____